NAME:_____ **TODAY'S DATE:**_____ **BIRTHDATE:**_____

TELEPHONE #:_____ **OK to leave a Message (Circle One) Yes / No**

SECONDARY PHONE #:_____ **OK to leave a Message (Circle One) Yes / No**

Which doctor are you here to see? (Circle One) Kinder / Phillips / Runnels / Hirsch / Bunton

REASON FOR VISIT (Circle One): Annual /Pregnancy/ or Problem _____

PREFERED PHARMACY (NAME/STREET/PHONE#) : _____

_____

Please allow at least 4 business days for refills to be called in.

****The pharmacy that you list as preferred is where all your meds from this office will be called in to, unless otherwise noted.***

ANY ALLERGIES? (Circle One) Yes / No If yes, list allergy and reaction: _____

_____

List any medications currently taking (INCLUDING VITAMINS & SUPPLEMENTS):

Name / Strength/ Frequency:	Name / Strength/Frequency:

How many times have you ever been pregnant?_____How many pregnancies were full-term?_____
How many pregnancies were pre-term?_____How many abortions have your ever had?_____
How many miscarriages have you had?_____How many children do you have living now?_____
New Pregnancy Information since your last visit:

#	Baby's Birthdate	Weeks pregnant at delivery	Number of Hours in Labor	Baby's Weight and Sex *Circle One below*	Delivery: Vaginal or C-section *Circle One below*	Miscarriage	Abortion Induced	Location (HOSP.)	Your Age At Delivery
				Male or Female **Weight: ____**	**Vaginal** **C- Section**				

(Check one if applicable)

Date of last period?_____ □ Hysterectomy □ Menopause
Do you have any new medical information or surgeries to report since your last visit to our clinic? _____

_____

Is there any new family history since your last visit?_____
Current marital status: (Circle one) Single / Married / Divorced / Widowed / Separated / Life Partner
Do you drink alcohol? (Circle one) Never / Rarely / Socially Do you drink caffeine? Yes / No
Do you smoke? (Circle one) Yes / No How many daily?_____ Are you sexually active? Yes / No
Current form of Birth Control:_____Date of last pap smear:_____Normal / Abnormal
Date of last mammogram:_____
Do you have any current complaints in regard to your women's health?_____

_____

Have you recently traveled out of state? Y / N OR traveled out of the country? Y / N

Signature:_____